COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, AUGUST 20, 2002

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

CASE NO. INS-2002-00170

Ex Parte: In the matter of
Adopting Revisions to the Rules
Governing Health Maintenance
Organizations

ORDER ADOPTING REVISIONS TO RULES

By order entered herein June 27, 2002, all interested persons were ordered to take notice that the Commission would consider the entry of an order subsequent to August 16, 2002, adopting certain revisions proposed by the Bureau of Insurance to the Commission's Rules Governing Health Maintenance Organizations effective September 1, 2002, unless on or before August 16, 2002, any person objecting to the adoption of the proposed revisions filed a request for a hearing with the Clerk of the Commission.

The Order to Take Notice also required all interested persons to file their comments in support of or in opposition to the proposed revisions on or before August 16, 2002.

The proposed revisions delete the mandatory maximum copayment requirements for health maintenance organizations and make them voluntary. The revisions also clarify the various cost sharing arrangements which may be imposed for supplemental

health care services and the requirement for dental services resulting from an accident.

As of the date of this Order, no request for a hearing has been filed with the Clerk of the Commission, and, as of the date of this Order, no comments have been filed with the Clerk of the Commission.

The Bureau has recommended that the proposed revisions be adopted; and

THE COMMISSION, having considered the proposed revisions and the Bureau's recommendation, is of the opinion that the proposed revisions should be adopted.

THEREFORE, IT IS ORDERED THAT:

(1) The revisions to Chapter 210 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Health Maintenance Organizations," which amend the rules at 14 VAC 5-210-70 and 14 VAC 5-210-90, and which are attached hereto and made a part hereof, should be, and they are hereby, ADOPTED to be effective September 1, 2002.

(2) AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to the Bureau of Insurance in care of Deputy Commissioner Gerald A. Milsky, who forthwith shall give further notice of the adoption of the revisions to the rules by mailing a copy of this Order, together with a clean copy of the revised rules, to all persons licensed by the Commission to transact the business of a health maintenance organization.

(3) The Commission's Division of Information Resources forthwith shall cause a copy of this Order, including a copy of

the attached revised rules, to be forwarded to the Virginia Registrar of Regulations for appropriate publication in the Virginia Register of Regulations.

(4) On or before August 23, 2002, the Commission's Division of Information Resources shall make available this Order and the attached revised rules on the Commission's website, http://www.state.va.us/scc/caseinfo/orders.htm.

(5) The Bureau of Insurance shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of paragraph (2) above.

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

CHAPTER 210.

RULES GOVERNING HEALTH MAINTENANCE ORGANIZATIONS.

14 VAC 5-210-70. General requirements.

A. Conversion of coverage.

1. Each health care plan shall offer to its enrollees, upon termination of coverage under a group or individual contract, the right to convert coverage, within 31 days after such termination of coverage, to an individual contract. Such converted coverage:

a. Shall provide benefits which, at a minimum, meet the requirements set forth in subsection B of 14 VAC 5-210-90; and

b. Shall not be refused on the basis that the enrollee no longer resides or is employed in the health maintenance organization's service area.

2. The conversion contract shall cover the enrollee covered under the group or individual contract as of the date of termination of the enrollee's coverage under such contract. Coverage shall be provided without additional evidence of insurability, and no preexisting condition limitations or exclusions may be imposed other than those remaining unexpired under the contract from which conversion is exercised. Any probationary or waiting period set forth in the conversion contract shall be deemed to commence on the effective date of coverage under the original contract.

3. A conversion contract shall not be required to be made available when:

a. The enrollee is covered by or is eligible for benefits under Title XVIII of the Social Security Act (Public Law 89-97, 79 Stat 286 (July 30, 1965));

b. The enrollee is covered by or is eligible for substantially the same level of hospital, medical, and surgical benefits under state or federal law;

c. The enrollee is covered by substantially the same level of hospital, medical, and surgical benefits under any policy, contract, or plan for individuals in a group;

d. The enrollee has not been continuously covered during the three-month period immediately preceding that enrollee's termination of coverage; or

e. The enrollee was terminated by the health care plan for any of the reasons stated in 14 VAC 5-210-80 B 1 a, b, c, and f.

B. Coordination of benefits.

1. A health care plan may include in its group contract or individual contract a provision that the value of any benefit or service provided by the health maintenance organization may be coordinated with any other health insurance or health care benefits or services that are provided by any other group policy, group contract, or group health care plan, including coverage provided under governmental programs, so that no more than 100% of the eligible incurred expenses is paid.

2. A health care plan shall not be relieved of its duty to provide a covered health care service to any enrollee because the enrollee is entitled to coverage under any other policy, contract, or health care plan. In the event that benefits are provided by both a health care plan and another

policy, contract, or health care plan, the determination of the order of benefits shall in no way restrict or impede the rendering of services required to be provided by the health care plan. The health maintenance organization shall be required to provide or arrange for the service first and then, at its option, seek coordination of benefits with any other health insurance or health care benefits or services that are provided by any other group policy, group contract, or group plan.

C. Copayments.

1. A health maintenance organization may require a copayment of enrollees as a condition for the receipt of specific basic health care services described in subsection B of 14 VAC 5-210-90. Such copayments shall be shown in the evidence of coverage as a specified dollar amount or as a percentage of the cost of providing such service for each specific basic health care service for which the health maintenance organization requires a copayment. ~~The maximum amount of copayment the health maintenance organization may require in any contract or calendar year shall not exceed 200% of the total annual premium per single member or family unit. The maximum copayment amount shall be based upon the actual premium charged, including any employer contributions, for that member or family's coverage. The maximum copayment amount shall be shown in the evidence of coverage as a specified dollar amount.~~

2. A health maintenance organization may impose cost sharing arrangements other ~~copayments for supplemental health care services~~ than those specified in this subsection for supplemental health care services.

3. ~~Each~~ If the health maintenance organization has an established copayment maximum, it shall keep accurate records of each enrollee's copayment expenses and notify the enrollee when his

copayment maximum is reached. Such notification shall be given no later than 30 days after the copayment maximum is reached. The health maintenance organization shall not charge additional copayments for the remainder of the contract or calendar year, as is appropriate. The health maintenance organization shall also promptly refund to the enrollee any copayments charged after the copayment maximum is reached. Any maximum copayment amount shall be shown in the evidence of coverage as a specified dollar amount, and the evidence of coverage shall clearly state the health maintenance organization's procedure for meeting the requirements of this subsection.

4. The provisions of this subsection shall not apply to any Family Access to Medical Insurance Security (FAMIS) Plan (i) authorized by the United States Centers for Medicare and Medicaid Services pursuant to Title XXI of the Social Security Act (42 USC §1397aa et seq.) and the state plan established pursuant to Chapter 13 (§32.1-351 et seq.) of Title 32.1 of the Code of Virginia and (ii) underwritten by a health maintenance organization.

D. Description of providers. A list of the names and locations of all affiliated providers shall be required to be provided to subscribers by the health maintenance organization at the time of enrollment or at the time the contract or evidence of coverage is issued and shall be made available upon request or at least annually.

E. Description of service area. A description of the service area within which the health maintenance organization shall provide health care services shall be required to be provided to subscribers by the health maintenance organization at the time of enrollment or at the time the contract or evidence of coverage is issued and shall be made available upon request or at least annually.

F. Extension of benefits.

1. Every group contract issued by a health maintenance organization shall contain a reasonable extension of benefits upon discontinuance of the group contract with respect to members who become totally disabled while enrolled under the contract and who continue to be totally disabled at the date of discontinuance of the contract.

2. Upon payment of premium, coverage shall remain in full force and effect for a reasonable period of time not less than 180 days, or until such time as the member is no longer totally disabled, or until such time as a succeeding carrier elects to provide replacement coverage to that member without limitation as to the disabling condition.

3. Upon termination of the extension of benefits, the enrollee shall have the right to convert coverage as provided for in subsection A of this section.

G. Freedom of choice.

1. At the time of enrollment each enrollee shall have the right to select a primary care physician from among the health maintenance organization's affiliated primary care physicians, subject to availability.

2. Any enrollee who is dissatisfied with his primary care physician shall have the right to select another primary care physician from among the health maintenance organization's affiliated primary care physicians, subject to availability. The health maintenance organization may impose a reasonable waiting period for this transfer.

H. Grievance procedure.

1. Each health maintenance organization shall establish and maintain a grievance or complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints. A record of all written complaints shall be maintained for a period of at least three years.

2. Every health maintenance organization shall provide complaint forms and/or written procedures to be given to enrollees who wish to register written complaints. Such forms or procedures shall include the address and telephone number to which complaints must be directed and shall also specify any required time limits imposed by the health maintenance organization.

3. The grievance system shall provide for complaints to be resolved within a reasonable period of time, not more than 180 days from the date the complaint is registered. This period may be extended (i) in the event of a delay in obtaining the documents or records necessary for the resolution of the complaint, or (ii) by the mutual written agreement of the health maintenance organization and the enrollee registering the complaint.

4. Pending the resolution of a written complaint filed by a subscriber or enrollee, coverage may not be terminated for the subscriber or enrollee for any reason which is the subject of the written complaint, except where the health maintenance organization has, in good faith, made an effort to resolve the complaint and coverage is being terminated as provided for in subsection B of 14 VAC 5-210-80.

5. Where enrollee complaints and grievances may be resolved through a specified arbitration agreement, the enrollee shall be advised in writing of his rights and duties under the agreement at the time the complaint is registered. No contract or evidence of coverage that entitles enrollees to

resolve complaints and grievances through an arbitration agreement shall limit or prohibit such arbitration for any claims asserted having a monetary value of $250 or more. If the enrollee agrees to binding arbitration his written acceptance of the arbitration agreement shall not be executed prior to the time the complaint is registered nor subsequent to the time an initial resolution is made, and the agreement must be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration.

14 VAC 5-210-90. Services.

A. Access to care.

1. Each health maintenance organization shall establish and maintain adequate arrangements to assure both availability and accessibility of adequate personnel and facilities providing health care services including:

a. Reasonable hours of operation and after-hours emergency health care;

b. Reasonable proximity to enrollees within the service area so as not to result in unreasonable barriers to accessibility;

c. Sufficient personnel, including health professionals, administrators, and support staff, to reasonably assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of enrollees; and

d. Adequate arrangements to provide inpatient hospital services for basic health care.

2. Each health maintenance organization shall make available to each enrollee the services of specialists as part of the provision of basic health care services.

B. Basic health care services.

1. Each health maintenance organization shall provide, or arrange for the provision of, as a minimum, basic health care services which shall include the following:

a. Inpatient hospital and physician services. Medically necessary hospital and physician services affording inpatient treatment to enrollees in a licensed hospital for a minimum of 90 days per contract or calendar year, except that services affording inpatient treatment for mental, emotional or nervous disorders, including alcohol and drug rehabilitation and treatment, shall be provided for not less than 30 days per contract or calendar year as medically necessary in a mental or general hospital or other licensed drug and alcohol rehabilitation facility; however, services for alcohol and drug rehabilitation may be limited to a service cost to the health maintenance organization or $80 per inpatient day up to the maximum of 30 days per contract or calendar year; provided, any payment made by the enrollee for services beyond the $80 per inpatient day limit shall not be included in or limited by the copayment limits prescribed by subsection C of 14 VAC 5-210-70. Enrollees may be subject to a 90-day lifetime limit for inpatient services for alcohol and drug rehabilitation. Hospital services include room and board; general nursing care; special diets when medically necessary; use of operating room and related facilities; use of intensive care unit and services; x-ray, laboratory, and other diagnostic tests; drugs, medications, biologicals, anesthesia, and oxygen services; special duty nursing when medically necessary; short-term physical therapy, radiation therapy, and inhalation therapy; administration of whole blood and blood plasma; and short-term rehabilitation services. Physician services include medically necessary health care services performed, prescribed, or supervised by physicians within a hospital for registered bed patients;

b. Outpatient medical services. Medically necessary health care services performed, prescribed or supervised by physicians for enrollees which may be provided in a nonhospital based health care facility, at a hospital, in a physician's office, or in the enrollee's home, and shall include consultation and referral services. Outpatient medical services shall also include diagnostic services, treatment services, short-term physical therapy and rehabilitation services the provision of which the health maintenance organization determines can be expected to result in the significant improvement of a member's condition within a period of 90 days, laboratory services, x-ray services, and outpatient surgery. Outpatient services for the treatment of mental, emotional, or nervous disorders, including alcohol and drug rehabilitation and treatment, shall not be required to be included as basic health care services but shall be made available to all group contracts as an additional outpatient service; however, services made available as follows shall be deemed to meet this requirement of availability:

(1) Twenty outpatient visits per member per year, as may be necessary and appropriate for short-term evaluative or crisis intervention mental health services, or both.

(2) Diagnosis, medical treatment and referral services, including referral services to appropriate ancillary services, for the abuse of or addiction to alcohol and drugs.

(a) Diagnosis and medical treatment for the abuse of or addiction to alcohol and drugs shall include detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis, whichever is medically determined to be appropriate, in addition to the other required basic health care services for the treatment of other medical conditions.

(b) Referral services may be either for medical or for non-medical ancillary services. Medical

services shall be a part of basic health care services.

Any outpatient services made available for the treatment of mental, emotional or nervous disorders, including alcohol and drug rehabilitation and treatment, may be subject to a copayment of not more than 50% of the cost of such services and limited for any applicable benefit period to a cost to the health maintenance organization as determined by it of no less than $1,000, provided, further, the copayment permitted hereby and any further copayment resulting from the cost limitation permitted hereby need not be included in or limited by the copayment limit prescribed by subsection C of 14 VAC 5-210-70.

c. Diagnostic laboratory and diagnostic and therapeutic radiologic services;

d. Preventive health services. Services provided with the goal of protection against and early detection and minimization of the ill effects and causes of disease or disability, including well-child care from birth, eye and ear examinations for children age 17 and under to determine the need for vision and hearing correction, periodic health evaluations, and immunizations; and

e. In and out of area emergency services, including medically necessary ambulance services, available on an inpatient or an outpatient basis 24-hours per day, seven-days per week.

2. Services not required to be provided as basic health care services, for the purpose of this section, include but are not limited to:

a. Except as required as a basic health care service in subdivision B 1 d, of this section, routine eye examinations or refractions, including examinations for astigmatism, myopia, or hyperopia; and eye glasses or contact lenses resulting from routine eye examinations;

b. Dental services other than those which are medically necessary as a result of accidental injury ~~which occurs while an individual is enrolled in the health care plan~~ for which treatment is covered as a basic health care service and for which treatment is requested by the enrollee within 60 days of the accidental injury;

c. Prescription drugs; and

d. Long-term physical therapy and rehabilitation.

C. Out-of-area benefits. In addition to out-of-area emergency services required to be provided as basic health care services, a health maintenance organization may offer to its enrollees indemnity benefits covering out-of-area services. A description of the procedure for obtaining any out-of-area services shall be included in the evidence of coverage as well as a statement of any restrictions or limitations on out-of-area services and any requirements that the health maintenance organization be contacted before obtaining such services. Any health care plan that requires the enrollee to contact the health maintenance organization before obtaining out-of-area services shall provide for emergency telephone consultation on a 24-hour per day, seven-day per week basis.

D. Supplemental health care services. In addition to the basic health care services required to be provided in subsection B of this section, a health maintenance organization may offer to its enrollees any supplemental health care services it chooses to provide.

Such services may be limited as to time and cost. Any copayment requirements provided for under subsection C of 14 VAC 5-210-70 ~~of this chapter~~ shall not apply to supplemental health care services.